Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders.

BIBLIOGRAPHIC SOURCE(S)

Connolly SD, Bernstein GA, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. J Am Acad Child Adolesc Psychiatry 2007 Feb;46(2):267-83. [129 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This updates a previous version: Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- May 12, 2006, Paxil (paroxetine) and Paxil CR: Changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information related to adult patients, particularly those who are younger adults.
- December 8, 2005, Paxil (paroxetine): Pregnancy category changed from C to D and new data and recommendations added to the WARNINGS section of prescribing information.
- September 27, 2005, Paxil (paroxetine) and Paxil CR: Changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information to describe the results of a retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **
SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Anxiety Disorders, including

- Separation anxiety disorder (SAD)
- Generalized anxiety disorder (GAD)
- Social phobia
- Specific phobia
- Panic disorder (with and without agoraphobia)
- Agoraphobia without panic disorder
- Selective mutism

Note: Posttraumatic stress disorder and obsessive-compulsive disorder have their own practice parameters and are not addressed in this guideline.

GUIDELINE CATEGORY

Diagnosis
Evaluation
Prevention
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Pediatrics
Psychiatry

INTENDED USERS

Allied Health Personnel
Physicians

GUIDELINE OBJECTIVE(S)

To review the evidence from research and clinical experience and to highlight significant advancements in the assessment and treatment of anxiety disorders since the previous parameter was published

TARGET POPULATION

Children and adolescents with or at risk for anxiety disorders

These guidelines are <u>not</u> intended for use in the following patients with anxiety disorders:

- Patients with post-traumatic stress disorder
- Patients with obsessive-compulsive disorder

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

1. Psychiatric assessment of children and adolescence, including routine use of screening questions about anxiety symptoms
2. Obtaining information about anxiety symptoms from multiple informants including the youths and adults (parents and/or teachers)
3. Use of self-report measures of anxiety for youth 8 years and older

Diagnosis/Evaluation

1. Formal evaluation to determine which anxiety disorder may be present, the severity of anxiety symptoms and functional impairment
2. Psychiatric assessment that considers differential diagnosis of other physical conditions and psychiatric disorders that may mimic anxiety symptoms (comorbid conditions)

Treatment

1. Multimodal treatment planning which considers the severity and impairment of the anxiety disorder, education of the parents and the child, and consultation with school personnel and primary care physicians
2. Psychotherapy (e.g. cognitive-behavioral therapy, psychodynamic psychotherapy, and family therapy)
3. Pharmacotherapy with selective serotonin-reuptake inhibitors (SSRIs) or other medications
4. Classroom-based accommodations
5. Treatment of comorbid conditions

Prevention

Early assessment and intervention

MAJOR OUTCOMES CONSIDERED

- Effectiveness of screening/evaluation interventions
- Severity of anxiety disorder symptoms or behaviors
- Level of functional impairment
- Treatment efficacy
- Remission of anxiety disorders
- Incidence of relapse
- Frequency of use of mental health services
- Incidence of comorbid disorders
- Identification of youth at risk for anxiety disorders

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The list of references for this parameter was developed by searches of Medline, OVIDMedline, PubMed, and PsycINFO; by reviewing the bibliographies of book chapters and review articles; and by asking colleagues for suggested source materials. The searches covered the period 1996 to 2004 and used the following text words: child, adolescent, and anxiety disorders. Each of these papers was reviewed, and only the most relevant references were included in the present document.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The recommendations are based on a thorough review of the literature as well as clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (such as randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but there may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the member forum at the 2004 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). During September 2005 to January 2006, a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts. This practice parameter was approved by AACAP Council on June 17, 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the categories of endorsement for the recommendation (MS, CG, OP, NE) are provided at the end of the "Major Recommendations" field.

Screening

Recommendation 1. The Psychiatric Assessment of Children and Adolescents Should Routinely Include Screening Questions About Anxiety Symptoms **[MS]**.

With the high prevalence of anxiety disorders in children and adolescents, routine screening for anxiety symptoms during the initial mental health assessment is recommended. Screening questions should use developmentally appropriate language and be based on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (May 2000 text revision) (DSM-IV-TR) criteria. Obtaining information about anxiety symptoms from multiple informants including the youths and adults (parents and/or teachers) is essential because of variable agreement among informants. Children may be more aware of their inner distress and parents or teachers may underestimate the severity or impact of anxiety symptoms in the child (e.g., general anxiety disorder [GAD]). However, adults may better appreciate the impact of anxiety on family or school functioning (e.g., separation anxiety disorder [SAD], social phobia). In addition, the anxious child's concerns about performance during the assessment and desire to please the interviewer can affect the child's report.

For youths 8 years and older, self-report measures for anxiety such as the Multidimensional Anxiety Scale for Children or Screen for Child Anxiety Related Emotional Disorders can assist with screening and monitoring response to treatment.

Evaluation

Recommendation 2. If the Screening Indicates Significant Anxiety, Then the Clinician Should Conduct a Formal Evaluation to Determine Which Anxiety Disorder May Be Present, the Severity of Anxiety Symptoms, and Functional Impairment **[MS]**.

For anxiety disorders, this evaluation should include differentiating anxiety disorders from developmentally appropriate worries or fears. Significant psychosocial stressors or traumas should be carefully considered during the evaluation to determine how they may be contributing to the development or maintenance of anxiety symptoms. Research in very young children is limited, but using play narrative assessment along with pictures, cartoons, and puppets to communicate during the diagnostic interview can be helpful. Differentiating the specific anxiety disorders can be challenging.

Although formal psychological testing or questionnaires are not required for the evaluation of anxiety disorders, there are several instruments that may be helpful in supplementing the clinical interview in youths 6-17 years old and in

differentiating the specific anxiety disorders. Clinicians may use sections of the available diagnostic interviews such as the Anxiety Disorders Interview Schedule for DSM-IV-Child Version (ADIS) or a checklist based on DSM-IV criteria. Measures for assessment and follow-up of specific anxiety disorders including social phobia, selective mutism, and specific phobia are also available.

The clinician should ask the parent and child about symptom severity and impairment in functioning along with the presence of anxiety symptoms during the assessment for childhood anxiety disorders. The ADIS has a Feelings Thermometer (ratings from 0-8) to help children quantify and self-monitor ratings of fear and interference with functioning. The ADIS has clinicians ask how much [type of anxiety] has "messed things up" for the child and stops the child from doing things he or she likes to do. Younger children may use more developmentally appropriate visual analogues such as smiley faces and upset faces to rate severity and interference.

Recommendation 3. The Psychiatric Assessment Should Consider Differential Diagnosis of Other Physical Conditions and Psychiatric Disorders That May Mimic Anxiety Symptoms **[MS]**.

Psychiatric conditions that may present with symptoms similar to those seen in anxiety disorders include attention-deficit/hyperactivity disorder (ADHD; restlessness, inattention); psychotic disorders (restlessness and/or social withdrawal); pervasive developmental disorders, especially Asperger's disorder (social awkwardness and withdrawal, social skills deficits, communication deficits, repetitive behaviors, adherence to routines); learning disabilities (persistent worries about school performance); bipolar disorder (restlessness, irritability, insomnia); and depression (poor concentration, sleep difficulty, somatic complaints).

Physical conditions that may present with anxiety-like symptoms include hyperthyroidism, caffeinism (including from carbonated beverages), migraine, asthma, seizure disorders, and lead intoxication. Less common in youths are hypoglycemia, pheochromocytoma, central nervous system (CNS) disorder (e.g., delirium, brain tumors), and cardiac arrhythmias. Prescription drugs with side effects that may mimic anxiety include antiasthmatics, sympathomimetics, steroids, selective serotonin-reuptake inhibitors (SSRIs), antipsychotics (akathisia), haloperidol, pimozide (neuroleptic-induced SAD), and atypical antipsychotics. Nonprescription drugs with side effects that may mimic anxiety include diet pills, antihistamines, and cold medicines.

Childhood anxiety disorders are commonly associated with somatic symptoms, such as headaches and abdominal complaints. The mental health assessment should be considered early in the medical evaluation process for youths with somatic complaints. It is important to assess somatic symptoms at baseline before initiating treatment to help the child and parents understand these symptoms and their relationship to the anxiety. Documenting physical symptoms before treatment with medication will decrease the likelihood of mistaking baseline somatic complaints as medication side effects.

Treatment

Recommendation 4. Treatment Planning Should Consider a Multimodal Treatment Approach **[CG]**.

A multimodal treatment approach for children and adolescents with anxiety disorders should consider education of the parents and the child about the anxiety disorder, consultation with school personnel and primary care physicians, cognitive-behavioral interventions, psychodynamic psychotherapy, family therapy, and pharmacotherapy. Selection of the specific treatment modalities for an individual child and family in clinical practice involves consideration of psychosocial stressors, risk factors, severity and impairment of the anxiety disorder and comorbid disorders, age and developmental functioning of the child, and family functioning. In addition, child and family factors such as attitudes or acceptance of a particular intervention and provider-practitioner factors such as training, access to evidence-based interventions, and affordability of such interventions need to be considered.

Recommendation 5. Treatment Planning Should Consider Severity and Impairment of the Anxiety Disorder **[CG]**.

Until evidence from comparative studies inform clinical practice, treatment of childhood anxiety disorders of mild severity should begin with psychotherapy. Valid reasons for combining medication and treatment with psychotherapy include the following: need for acute symptom reduction in a moderately to severely anxious child, a comorbid disorder that requires concurrent treatment, and partial response to psychotherapy and potential for improved outcome with combined treatment. Residual anxiety disorder symptoms can increase the risk for maintenance or relapse of the same or a comorbid anxiety disorder. Therefore, it is recommended that functional impairment, not just anxiety symptom reduction, be monitored during the treatment process.

Recommendation 6. Psychotherapy Should Be Considered as Part of the Treatment of Children and Adolescents With Anxiety Disorders **[CG]**.

Cognitive Behavioral Therapy

In cognitive-behavioral therapy (CBT), the clinician teaches the child adaptive coping skills and provides practice opportunities to develop a sense of mastery over anxiety symptoms or situations that are associated with distress and impairment. Given limitations in the translation of CBT to community practice, a broad array of psychosocial interventions and multimodal treatments need to be flexibly considered so that individual children and families receive the most comprehensive treatment available to them.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy for anxiety disorders uses a case formulation informed by one or more of several psychodynamic theoretical perspectives (ego psychology, object relationships, attachment, temperament, motivational, self-psychology, and intersubjective) and incorporates the assessment of the patient's developmental accomplishments and difficulties. Supportive and expressive techniques are used to decrease internal conflict and enhance regulation of affect and impulses, allowing the individual to develop appropriate signal anxiety.

Parent-Child and Family Interventions

Interventions that improve parent-child relationships, strengthen family problem solving, reduce parental anxiety, and foster parenting skills that differentially reinforce adaptive coping and appropriate autonomy in the child are often incorporated into a range of psychotherapeutic interventions with anxious children. Clinicians who conduct CBT and psychodynamic psychotherapy with anxious children routinely involve parents in the treatment process.

Family therapy examines issues in the context of family structure and process rather than focusing on an individual.

Recommendation 7. SSRIs Should Be Considered for the Treatment of Youths With Anxiety Disorders **[CG]**.

SSRIs have emerged as the medication of choice in the treatment of childhood anxiety disorders. When anxiety disorder symptoms are moderate or severe or impairment makes participation in psychotherapy difficult, or psychotherapy results in a partial response, treatment with medication is recommended. SSRIs have generally been well tolerated for childhood anxiety disorders, with mild and transient side effects that included gastrointestinal symptoms, headaches, increased motor activity, and insomnia. Less common side effects such as disinhibition should also be monitored. The clinician should routinely screen for bipolar disorder or family history of bipolar in youths before treatment with an SSRI.

Whereas controlled trials have established the safety and efficacy of short-term treatment with SSRIs for childhood anxiety disorders, the benefits and risks of long-term use of SSRIs have not been studied. One study recommends that clinicians may consider a medication-free trial for children who have a significant reduction in anxiety or depressive symptoms on an SSRI and maintain stability in these symptoms for 1 year. This trial off medication should be during a low stress period, and the SSRI should be reinitiated if the child or adolescent relapses.

There is no empirical evidence that a particular SSRI is more effective than another for treatment of childhood anxiety disorders. Clinically, the choice is often based on side effects profile, duration of action, or positive response to a particular SSRI in a first-degree relative with anxiety. In addition, the risk-benefit ratio for a medication trial needs to be carefully assessed because CBT has been shown to be effective and long-term side effects of medications have not been studied in youths.

At this time, there are no specific dosing guidelines for children and adolescents with anxiety disorder. Review articles recommend starting at low doses, monitoring side effects closely, and then increasing the dose slowly on the basis of treatment response and tolerability. Clinicians need to appreciate that anxious children and anxious parents may be especially sensitive to any worsening in the child's somatic symptoms or emergence of even transient side effects of medications.

Recommendation 8. Medications Other Than SSRIs May Be Considered for the Treatment of Youths With Anxiety Disorders **[OP]**.

The safety and efficacy of medications other than SSRIs for the treatment of childhood anxiety disorders have not been established. However, noradrenergic antidepressants (venlafaxine and tricyclic antidepressants [TCAs]), buspirone, and benzodiazepines have been suggested as alternatives to be used alone or in combination with the SSRIs. Data are limited in childhood anxiety disorders to guide treatment with combinations of medications when a single medication is not effective in managing symptoms. Comorbid diagnoses are strongly considered in selection of medication.

Recommendation 9. Treatment Planning May Consider Classroom-Based Accommodations **[OP]**.

The clinician could consider the following classroom-based accommodations when anxiety disorders interfere with school functioning. If anxiety interferes with homework completion, then the length of homework assignments should be modified to an amount commensurate with the student's capacity. If anxiety is overwhelming at school, then an adult outside the immediate classroom should be identified who can assist the child with problem-solving or anxiety management strategies. If performance or test anxiety is present, then testing in a quiet, private environment may reduce excess anxiety. It is often helpful to educate the classroom teacher about the nature of the child's anxiety and suggest strategies that facilitate the student's coping. The clinician may recommend that these specific accommodations for the anxiety disorder be written into the student's 504 Plan or Individualized Educational Plan.

Comorbidity

Recommendation 10. Comorbid Conditions Should Be Appropriately Evaluated and Treated **[MS]**.

Anxiety disorders are highly comorbid with other anxiety disorders and with other psychiatric disorders including depression, ADHD, and substance abuse. Other commonly co-occurring conditions include oppositional defiant disorder, learning disorders, and language disorders. Comorbid disorders may affect functioning and treatment outcome. They should be assessed and may benefit from being treated concurrently with the anxiety disorder. Diagnosis is complicated by overlapping symptoms between anxiety disorders and comorbid conditions, which can lead to misdiagnosis and underdiagnosis of comorbidity. Inattention, for example, may be present in anxiety, ADHD, depression, learning disorders, and substance abuse. A common clinical phenomenon is the recognition of a comorbid diagnosis once the primary diagnosis is treated and additional symptoms become more evident.

The presence of comorbid major depression increases with older age, is associated with greater severity and impairment of the anxiety disorder, is more likely to be associated with social anxiety, and may be a poor prognostic indicator. A child with severe depression may not be able to participate in CBT effectively. Treatment of depression needs to be prioritized with initiation of an SSRI antidepressant medication recommended early in the treatment process. Careful monitoring of suicide risk is recommended.

Children with anxiety disorders are at greater risk of alcohol abuse in adolescence. Comorbid alcohol abuse/dependence in adolescents should be assessed and

considered in treatment planning with anxiety disorders. Based on the temporal relationship between childhood anxiety disorders and risk of alcoholism in adolescents, it is suggested that some adolescents use alcohol to reduce anxiety symptoms. CBT may be effective in reducing anxiety if the alcohol abuse is treated, and developing alternative coping strategies to address anxiety may help to reduce alcohol consumption.

The presence of comorbid bipolar disorder is an important factor in medication choice because of the possibility that SSRIs and other antidepressants may exacerbate symptoms of bipolar disorder. Youths with anxiety disorders should be screened for bipolar disorder and family history of bipolar disorder before initiating a medication trial.

Prevention

Recommendation 11. Early Assessment and Intervention May Be Considered in Treatment and Prevention of Childhood Anxiety Disorders **[OP]**.

With older age, increased severity of symptoms, parental psychopathology, and family functioning difficulties as significant predictors of poorer treatment outcome, early intervention, and prevention offer a proactive method for alleviating anxiety symptoms in youths. In addition, targeting empirically based risk factors that are amenable to change with evidence-supported intervention satisfies the prerequisites for effective prevention. Opportunities for early intervention and prevention exist for childhood anxiety disorders and may include community screening and early assessment, early interventions in community settings, media-based and community-based psychoeducational programming, classroom-based programs, parent skills-training programs, and screening and treatment of parental anxiety disorders. Several of these are discussed in further detail.

Community screening and early assessment can identify anxious youths at greatest risk by using brief self-report screening measures such as the Multidimensional Anxiety Scale for Children and the Screen for Child Anxiety Related Emotional Disorders for anxiety symptoms and/or by teacher nomination. Group interventions with CBT in school and other community settings can provide effective early treatment for children with mild to moderate anxiety disorders, which may improve long-term functioning. Clinicians are encouraged to refer patients for early-intervention CBT even if anxiety symptoms are mild or subclinical. Adaptation of protocol-based CBT interventions to fit diverse populations and take into account the limitations of community resources, including those of inner-city minority youths, can make evidence-supported treatments feasible and transportable. Parent skills-training programs that teach parents anxiety management and foster healthy parent-child relationships may reduce the development of anxiety disorders in young children at risk.

Definitions:

Rating Scheme for the Strength of the Recommendations

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[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but not required. There may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] Not endorsed refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved assessment and treatment of children and adolescents with anxiety disorders

POTENTIAL HARMS

- Side effects of pharmacological agents. For example, mild and transient side effects of selective serotonin-reuptake inhibitors (SSRIs) include gastrointestinal symptoms, headaches, increased motor activity, and insomnia, as well as less common side effects such as disinhibition. Possible side effects of benzodiazepines include sedation, disinhibition, cognitive impairment, and difficulty with discontinuation. The most common adverse side effects of buspirone in youths are lightheadedness, headache, and dyspepsia.

- Clinicians should use benzodiazepines cautiously because of the possibility of developing dependency.
- SSRIs and other antidepressants may exacerbate symptoms of bipolar disorder.

CONTRAINDICATIONS

CONTRAINDICATIONS

Benzodiazepines are contraindicated in adolescents with substance abuse.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The current evidence offers support for the short-term efficacy and long-term effectiveness of child-focused cognitive-behavioral therapy (CBT) for childhood anxiety. However, child-focused CBT is not effective for all children with anxiety disorders, and about 20% to 50% may continue to meet criteria for an anxiety disorder after treatment.
- Whereas controlled trials have established the safety and efficacy of short-term treatment with selective serotonin-reuptake inhibitors (SSRIs) for childhood anxiety disorders, the benefits and risks of long-term use of SSRIs have not been studied.
- Clinicians should use benzodiazepines cautiously because of the possibility of developing dependency.
- Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision making. American Academy of Child and Adolescent Psychiatry practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician - after considering all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources - must make the ultimate judgment regarding the care of a particular patient.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Connolly SD, Bernstein GA, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. J Am Acad Child Adolesc Psychiatry 2007 Feb;46(2):267-83. [129 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 2007 Feb)

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

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This parameter was developed by: Sucheta D. Connolly, M.D.; Gail A. Bernstein, M.D.

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Members of the consensus group were asked to identify any conflicts of interest they may have with respect to their role in reviewing and finalizing the content of this practice parameter. One of the consensus group members was on the speakers' bureau for the following pharmaceutical companies: Eli Lilly, Novartis, Ortho-McNeil, and Shire.

The authors had no financial relationships to disclose.

GUIDELINE STATUS

This is the current release of the guideline.

This updates a previous version: Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):69S-84S.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

A CD-ROM containing all parameters is available for a fee. See the AACAP Publication Store for more information.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on March 5, 2007. The updated information was verified by the guideline developer on April 3, 2007. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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